**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

SHIRANG NEURGAONKAR, MD
3100 TIMMONS LN STE 250
HOUSTON, TX 77027

**Respondent Name**

FIDELITY & GUARANTY INSURANCE

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-12-1086-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "CARRIER REFUSES TO PAY FULL AMOUNT FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION HAS BEEN SUBMITTED."

**Amount in Dispute:** $300.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier challenges whether the charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden, & Latson, P.O. BOX 201320, Austin, TX 78720

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 17, 2011 | 99456-W5-WP | $300.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 22 2011
   - 4 –THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFER USED OR A REQUIRED MODIFIER IS MISING.
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL.

   Explanation of benefits dated June 28, 2011
   - 18 – Duplicate claim/service

**Issues**

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The requestor initially billed on March 28th, 2011, the amount of $500.00 for CPT code 99456-WP-W5 with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The requestor later amended the billing on April 13th, 2011 to change the number of units to 2 (two) in box 24G as well as the total billed charges to $800.00 for CPT code 99456-W5-WP. Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the non musculoskeletal condition of the right ear is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) with a MAR of $150.00. The total MAR for the MMI/IR exam is $500.00. The extent of injury is not in question and multiple impairment rating was not requested, nor billed using additional line item CPT code 99456-MI. There was no request for an IR examination for either a facial or head/scalp contusion on the DWC-32. The request was to examine the right ear only. MMI/IR MAR is $500.00.
2. Respondent has paid $500.00 on CPT code 99456-W5-WP and no additional amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 29, 2012<br>Date |
|---|---|---|

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.